DRAFT

Washington State Board of Health

Nationwide Survey of State Boards of Health

June 2003

EXECUTIVE SUMMARY

In 1889, the Washington State Constitution created the Washington State Board of Health (WSBOH) to lead efforts to provide public health protections to all state residents. Today, WSBOH continues to serve the people of Washington State by working to understand and prevent disease across the entire population.

In 2001, WSBOH sought to place its work in a national context by better understanding the roles state boards of health play in other states. It found that current information about state boards across the nation did not exist. During 2002-03, WSBOH conducted its own nationwide survey to assess the number and types of state boards of health in other states. This report describes the results of that study. It also includes information and discussion about efforts to re-establish state boards in two states, to generate a model public health act that could include a statewide advisory council, and to define public health governance performance standards that could apply to state boards of health.

WSBOH identified state boards of health or councils meeting the study criteria in 30 states. Of these 30 boards, 22 (73%) make policy and provide advice. Eight (27%) are advisory only. Of the 22 boards with policy-making authority, eight (36%) oversee or direct the state health agency. (See Appendix B for brief discussion of each board.) There was a net loss of two qualifying state boards and councils nationwide between 1991 and June 30, 2003. The identification of 30 states with qualifying boards and councils is generally consistent with the results of previous surveys, although study methods and criteria varied.

The report demonstrates that the public health system in Washington State remains in the mainstream nationally. If one considers the powers and duties of state boards of health as a continuum—with boards that have direct oversight of the statewide public health system on one end and boards that are strictly advisory to the executive officer of the state health agency on the other—WSBOH appears to fall somewhere in the middle of the continuum. While a few states eliminated their state boards of health during the 1990s, there is no nationwide trend that would point to the widespread elimination of state boards. Indeed, some states that eliminated their boards either have re-established them or are considering recommendations to re-establishing them.

The authors recommend the following next steps for WSBOH and its staff:

1. Provide survey information to key contacts at boards of health and health agencies in other states.
2. Share information with the Centers for Disease Control and Preventions (CDC) and the Association of State and Territorial Health Officials (ASTHO) to assist them in updating their records of state boards of health.
3. As other projects permit, be available to work with NALBOH and other associations as appropriate to support efforts to create a national forum for state boards of health.
4. As other projects permit, be available to work with the CDC National Public Health Performance Standards Program, the Washington Public Health Improvement Partnership, and other entities as appropriate to support efforts to develop governance tools applicable to state boards of health.

INTRODUCTION

In 1889, the Washington State Constitution created the Washington State Board of Health (WSBOH) to lead efforts to provide public health protections to all state residents. Today, WSBOH continues to serve the people of Washington State by working to understand and prevent disease across the entire population. It provides leadership by suggesting public health policies and actions, regulating certain activities, and providing a public forum. It works in concert with the Washington State Department of Health, local health jurisdictions, and the local boards of health that govern them, and with the many other agencies, organizations, and groups that share responsibility in the public health system. (See Appendix A for a description of the organization and duties of WSBOH.)

In 2001, WSBOH sought to place its work in a national context by better understanding the roles state boards of health play in other states. It found that current information about state boards across the nation did not exist.

The Centers for Disease Control and Prevention (CDC) conducted a survey of state and territorial public health systems in 1989 and 1990. As part of that survey, it asked states whether they had a state health board or commission. The CDC published its findings in a 1991 report called *Profile of State Health and Territorial Public Health Systems: United States, 1990*[1]. That same year, the Public Health Foundation (PHF) published the *1991 Public Health Chartbook,*[2] which included a listing of state boards of health. Organizations involved with the 1991 studies say that no surveys have been completed on the subject since then.

During 2002-03, WSBOH conducted its own nationwide survey to assess the number and types of state boards of health in other states. This report describes the results of that study. It also includes information and discussion about efforts to re-establish state boards in two states, to generate a model public health act that could include a statewide advisory council, and to define public health governance performance standards that could apply to state boards of health.

The contents of this study will help place the work of the Washington State Board of Health in a national context. It should also contribute to discussions going on across the country about public health system policy development, governance, and leadership in general and about the role of state boards specifically.

[1] Centers for Disease Control and Prevention, 1991. *Profile of State Health and Territorial Public Health Systems: United States, 1990,* http://wonder.cdc.gov/wonder/sci_data/misc/type_txt/stprof91.asp
[2] Public Health Foundation, 1991. *1991 Public Health Chartbook*.

METHODOLOGY

The authors of this study identified whether a state board of health existed in each state. They then compared these boards' powers, duties, and structures. The authors utilized existing information provided by the CDC and StatePublicHealth.org, a product of the Association of State and Territorial Health Officials (ASTHO) and its affiliates. They visited state health agency and board of health Web sites, as well as relevant portions of each state's statutes. They followed up this research whenever possible by conducting short phone interviews with contacts for state health agencies and state boards. Finally, they asked contacts with each state to verify a summary describing its board.

For the purposes of this study, a body had to meet four criteria to be considered a "state board of health":

1. Authority: The board must have assigned advisory authority and/or regulatory authority to protect and promote the health of the state population. Advisory authority includes regular or periodic recommendations to the governor, the primary state health agency, and in many cases, the state legislature. A board's authority may also include serving as a public forum. Regulatory authority includes the power to set health policy, to determine specific regulations, and/or to oversee the state health agency.
2. Appointments: Board members must be formally appointed to serve by the governor and/or are determined by state law. Board members must also be assigned set terms.
3. Staff: The board must have staff assigned to facilitate its required responsibilities. Staff may be provided by the state health agency or be independently hired to serve the board.
4. Funding: The board must have a budget to perform its functions. These funds may be from by the state, from the federal government and/or through other specified means. Specific budgets do not need to be identified.

Any state agency that meets all the criteria is considered a state board of health regardless of whether it is called a board, council, commission, or committee. For purposes of this report, the terms *state board of health, board* and *council* refer to all entities meeting the criteria.

For comparison purposes, the authors also gathered information about each state board's authority, board composition, staffing, funding, and relationships with local health jurisdictions. They asked whether the board's authority was advisory or and/or regulatory, and compared several areas of regulatory authority. The variables related to board composition included numbers and types of members, length of terms, and how and by whom they were selected or appointed. The information analyzed for local health jurisdictions was whether the local health jurisdiction was directed by the state government (state control) or was part of local government (local control). Where possible, the authors identified the number of local health departments within the state.

FINDINGS

WSBOH identified state boards of health or councils meeting the study criteria in 30 states. Of these 30 boards, 22 (73%) make policy and provide advice. Eight (27%), are advisory only. Of the 22 boards with policy-making authority, eight (36%) oversee or direct the state health agency. (See Appendix B for brief discussion of each board.) There was a net loss of two qualifying state boards and councils nationwide between 1991 and June 30, 2003.

The identification of 30 states with qualifying boards and councils is generally consistent with the results of previous surveys, although study methods and criteria have varied.

In 1986, the Philip Morris U.S.A. tobacco company, concerned about New York State Public Health Council efforts to enact a smoking ban, surveyed the statutes in all 50 states to identify those with "health boards and commissions." It reported 34 states had boards and commissions, and ten of those held broad powers or emergency powers.[3]

The CDC *Profile* reported, "State boards or councils of health are used for citizen input into the operation of the SHA [state health agency] by 40 (80%) states. These boards or councils function in a policy-making capacity in 21 (42%) states, in an advisory capacity in 17 (34%), and in both capacities in 2 (4%)." The *Profile* reported a higher number in part because it included boards and councils that would not have met the criteria for this study.

StatePublicHealth.org, a project of the Association of State and Territorial Health Officials (ASTHO), currently maintains the State Health Information Profile Database. The database's information about state boards of health is based largely on the 1991 reports. The database lists 34 states with state boards of health. A variety of factors—misreporting, differing interpretations, and changes in the status of state boards—contribute to the discrepancies between the ASTHO data and the WSBOH findings (see Table 1):

- Three states have eliminated their state boards since 1991. Delaware suspended its State Board of Health in 1996. A year later, Florida eliminated its Statewide Health Council. Montana eliminated its Public Health Advisory Council in as part of reorganization in the mid-1990s. (Utah eliminated its Health Advisory Council in 1993, but reinstated it in 2002).
- West Virginia established the Public Health Advisory Council in 2000 (it is scheduled to sunset on June 30, 2003).,
- Three states shown as having a state board in the ASTHO database eliminated their state boards prior to 1991. Michigan eliminated its in 1978; Minnesota in 1979. The authors could not find any evidence that a state board has operated in Rhode Island in recent decades (a finding supported by the CDC *Profile*, which listed no Rhode Island board).
- WSBOH determined that the Georgia Board of Human Resources, which ASTHO did not recognize, meets the study criteria.

[3] Philip Morris U.S.A, 1986. Interoffice memorandum from Pat Wilson to John Kochevar, December 12, 1986, http://tobaccodocuments.org/state_strategies/104.html

Table 1: Comparison of CDC, ASTHO, and WSBOH findings

	CDC	ASTHO/PHF	WSBOH	Notes
1. AK	N	N	N	
2. AL	Y	Y	Y	
3. AR	Y	Y	Y	
4. AZ	N	N	N	
5. CA	N	N	N	
6. CO	Y	Y	Y	
7. CT	N	N	N	
8. DE	**Y**	**Y**	**N**	**SBOH suspended in 1996**
9. FL	**Y**	**Y**	**N**	**SHC abolished in 1997**
10. GA	**Y**	**N**	**Y**	**BHR fits WSBOH criteria**
11. HI	Y	Y	Y	
12. IA	Y	Y	Y	
13. ID	Y	Y	Y	
14. IL	Y	Y	Y	
15. IN	Y	Y	Y	
16. KS	**Y**	**N**	**N**	**No change from ASTHO**
17. KY	Y	Y	Y	
18. LA	N	N	N	
19. MA	Y	Y	Y	
20. MD	Y	Y	Y	
21. ME	N	N	N	
22. MI	**Y**	**Y**	**N**	**SBOH abolished in 1978**
23. MN	**N**	**Y**	**N**	**SBOH abolished in 1976**
24. MO	Y	Y	Y	
25. MS	Y	Y	Y	
26. MT	Y	Y	Y	
27. NC	Y	Y	Y	
28. ND	Y	Y	Y	
29. NE	Y	Y	Y	
30. NH	N	N	N	
31. NJ	Y	Y	Y	
32. NM	N	N	N	
33. NV	Y	Y	Y	
34. NY	Y	Y	Y	
35. OH	Y	Y	Y	
36. OK	Y	Y	Y	
37. OR	Y	Y	Y	
38. PA	**Y**	**N**	**N**	**No change from ASTHO**
39. RI	**N**	**Y**	**N**	**No evidence of SBOH**
40. SC	Y	Y	Y	
41. SD	N	N	N	
42. TN	**Y**	**N**	**N**	**No change from ASTHO**
43. TX	Y	Y	Y	
44. UT	Y	Y	Y	
45. VA	Y	Y	Y	
46. VT	Y	Y	Y	
47. WA	Y	Y	Y	
48. WI	N	N	N	
49. WV	**Y**	**N**	**Y**	**Established 2000 (sunsets 2004)**
50. WY	**Y**	**N**	**N**	**No change from ASTHO**

According to the findings of this study, the 30 states with state boards of health are:

Alabama	Arkansas	Colorado	Georgia	Hawaii
Idaho	Illinois	Indiana	Iowa	Kentucky
Maryland	Massachusetts	Mississippi	Missouri	Nebraska
Nevada	New Jersey	New York	North Carolina	North Dakota
Ohio	Oklahoma	Oregon	South Carolina	Texas
Utah	Vermont	Virginia	Washington	West Virginia

The 20 states without an identified state board of health are:

Alaska	Arizona	California	Connecticut	Delaware
Florida	Kansas	Louisiana	Maine	Michigan
Montana	Minnesota	New Hampshire	New Mexico	Pennsylvania
Rhode Island	South Dakota	Tennessee	Wisconsin	Wyoming

Authority

All 30 states have boards with advisory authority and 22 of those states (73%) have boards with policy-making and regulatory power as well. Of the boards with policy-making authority, eight directly oversee the state health agency. In many cases, the boards with policy-making and regularity authority set statewide health objectives and priorities. They likely adopt, promulgate, amend, and repeal rules and regulations. All appear to regularly advise the governor and frequently the legislature and the head of the state health agency. Many are required to provide specific periodic reports providing direct guidance about the overall health system and public health specifically. The boards all serve as public forums.

The authors gathered information about several categories of regulatory authority and compared them across all states boards of health (see Appendix C). Using key responsibilities held by the Washington State Board of Health as a reference point, the authors gathered information about: immunization policy; visual/auditory screening; vital statistics; heritable/metabolic disorders (newborn screening); permits, emergency medical services (EMS)/trauma; control of infectious diseases; control of noninfectious diseases; funeral directors; school health; hazardous substances/contamination; shellfish; food safety; ventilation; water systems; on-site sewage; regulation of health professions; pesticide poisonings; and the authority to impose violations, remedies, and penalties to local health jurisdictions.

Membership

Appointments: The governor appoints members in all but one state. In that state (Alabama) the state medical association chooses members from among its members. Nine states have board appointments that must be confirmed by the legislature. One of those states (North Carolina), has a board appointed by both the governor and the state medical society.

Number: The number of board members on a state board of health ranges from six in Texas to 23 in Arkansas. In every state, board members have specific terms and board members fill specified slots. Types of appointees included: doctors, dentists,

representatives from state public health or medical association, registered nurses, sanitarians, hospital administrators, consumer representatives, veterinarians, members from a local health jurisdiction and representatives from academia (medical or public health). In some states the appointments have political party affiliations or represent state political districts.

Staffing

Every state board has staff. Thirteen states have fulltime independent staff serving the board and 17 states have staff provided by the state health agency.

Funding

Most state boards are funded with state dollars and in many cases funding is through the state health agency. It is unclear, however, whether those state funds are controlled by state health agency or only administered by the state health agency as a pass-through. Five states have federal as well as state funding. Alabama is the only state strictly funded by state medical association dues and private donations. Nearly all states were unable or unwilling to provide any detailed information about their actual budgets; therefore, budget amounts are not reported in this study.

Relationships with Local Health Jurisdictions

The governance structure in every state varies. In some, the state governs the entire public health system. In others, such as Washington, local governments have independent authority and responsibilities. Some states even have both kinds of structures operating depending on where you are in that state. Six states have local health jurisdictions that are solely extensions of state government. Ten states have local health jurisdictions that are solely part of local government. Eight states have some local health jurisdictions that are part of state government and some part of local government. In five states state and local government share responsibility. Hawai'i has a state health department, which is headquartered on Oahu and operates district offices on the three largest neighbor islands.[4]

[4] For more information about state and local health relationships, see National Association of County and City Health Officers, *NACCHO Survey Examines State/Local Health Department Relationships*, Research Brief, October 1998, Number 2.

Table 2: Characteristics of State Board of Health

State	Authority		Members		Staff		Funding		LHJs
	Advisory	Regulatory	No.	Appointment	Agency	Board	State	Federal	Control
1. Alabama	X	X	12	SMA*		X	Dues/Donations		Shared
2. Arkansas	X	X	23	Governor	X		X		State
3. Colorado	X	X	9	Governor		X	X		Local
4. Georgia	X	X	15	Governor	X		X		Local
5. Hawaii	X		11	Governor	X		X	X	State
6. Idaho	X	X	7	Governor		X	X	X	Local
7. Illinois	X		15	Governor	X		X		State/Local
8. Indiana	X	X	11	Governor	X		X		Local
9. Iowa	X	X	9	Governor	X		X		State
10. Kentucky	X		19	Governor	X		X		Shared
11. Maryland	X		7	Governor	X		X		Shared
12. Massachusetts	X	X	8	Governor	X		X		State/Local
13. Mississippi	X	X	13	Gov/Leg	X		X		State/Divided
14. Missouri	X		7	Gov/Leg	X		X		Local
15. Nebraska	X	X	17	Gov/Leg	X		X		Local/Divided
16. Nevada	X	X	7	Governor		X	X		State/Local
17. New Jersey	X	X	8	Gov/Leg	X		X		Local
18. New York	X	X	15	Gov/Leg	X		X		State/Local
19. N. Carolina	X	X	13	Gov/SMA*		X	X		Shared
20. North Dakota	X	X	11	Governor	X		X		Local
21. Ohio	X	X	7	Governor	X		X		Shared/Divided
22. Oklahoma	X	X	9	Gov/Leg		X	X		State/Local
23. Oregon	X		15	Governor		X	X		Local
24. S. Carolina	X	X	7	Gov/Leg		X	X	X	State
25. Texas	X	X	6	Gov/Leg		X	X	X	State/Local
26. Utah	X		9	Governor		X	X		Local
27. Vermont	X	X	7	Gov/Leg	X		X		State
28. Virginia	X	X	11	Governor		X	X	X	State
29. West Virginia	X		15	Gov/Leg		X	X		State
30. Washington	X	X	10	Governor		X		X	Local

* SMA=State Medical Association

DISCUSSION

Massachusetts established the first state board of health in 1869 (although the Hawai'i territorial board predates that). By 1900, there were 40 state boards of health among the 45 states. These boards were the original vehicles by which states provided for the protection of the public health and welfare, fulfilling one of the most basic responsibilities of government. The National Conference of State Boards of Health, the first organization to provide a forum for state and territorial health officials, formed in 1884.

In the intervening decades, public health programs activities have expanded greatly and large public health agencies have grown up underneath or alongside state boards of health (either as freestanding executive agencies or as divisions within larger health and social services agencies). In a host of policy areas, many states have moved away from a “boards and commissions” model of government, and toward a “strong governor” model where the chief executive has direct authority over agency heads.

In public health, the result has been a wide variety of government structures. In some states, state boards are still the main state health agency or have direct oversight over its activities. In other states, boards have been eliminated or reduced to purely advisory status. In still others, the state boards retain some or all of their regulatory authorities but have no say in the management of agency programs.

The National Conference of State Boards of Health has gone through several metamorphoses over the years, emerging in 1942 as ASTHO. Membership in ASHTO is limited to executive officers of the departments of health. State boards of health currently have no national organization—no regular forum to share their similarities, differences, accomplishments, challenges, and strategies. Almost every state representative contacted directly expressed interest in knowing about other states with boards.

This survey shows that in 60 percent of the states in the county, state boards of health are involved to the governance and oversight of the public health system. The 30 state boards of health that operate across the country work in many similar ways to protect and to promote the health each of their state’s populations.

Their actual role in the governance structure varies widely. For example, Hawai'i state law requires that the board of Health exist as an advisory body, but the statute doesn’t specify any authority or responsibility. In practice, the Hawai'i State Board of Health has no substantive role in state public health governance. It is primarily an advisory body for the state’s Public Health Block Grant.

Most state boards, however, still play an important leadership role in their state systems, whether they serve as advisory or regulatory bodies. Within their states, they each work in concert with the state health agency that generally implements public health policy. They typically make recommendations to their respective governors on ways to improve their public health systems. And they each provide an opportunity for the general public to voice their concerns about any public health issue that concerns them.

While four state boards have been eliminated in the last decade or so, two states have also re-established state boards (one was re-established after being eliminated and one is scheduled to sunset). And in two states, efforts are underway to re-establish boards.

In California, the Little Hoover Commission completed a study in April 2003—*To Protect and Prevent: Rebuilding California's Public Health System*[5]—recommending the reconstitution of its state board of heath as part of California's major public health system reform. The California report states that a significant gap exists in California's public health system because there is no public forum to identify needs, expose problems, and set priorities. There is no public process for public at risk; no expert involvement in a public venue; no venue for linking public efforts; and no venue for systematically thinking through health-related issues. California looked to Washington for a model state board of health that fulfills the responsibility for oversight, public input, expert involvement, coordination, and policy development. (See the discussion of the Little Hoover Commission process in Appendix D.)

In September 2002, a coalition of Michigan health care organizations and leaders issued a report called *The Health of the Public in Michigan: A Vision for the Twenty-First Century*.[6] The report noted that the elimination of boards and commissions had limited public participation in public health governance. It called for the re-establishment of a state board of health to conduct regular public health assessments and provide longer-term vision for delivering public health essential services across the entire state. This year, several of the participants in that process, including the Michigan Public Health Association and the Michigan Council for Maternal and Child Health have endorsed resolutions calling for the re-establishment of a state board.

The beneficial role of state boards and councils—at least as advisory bodies—has also been recognized by The Turning Point Public Health Statute Modernization Collaborative, which is developing "The Model State Public Health Act." A discussion draft of the model act released for comment January 31 calls for establishment of a "public health advisory council." As described in the model act, the council would meet the criteria for a state board established for this study. (See the discussion of the model act in Appendix E.)

Efforts are also underway to establish a forum for state boards. Currently, the by-laws of the National Association of Local Board of Health (NALBOH) allow state boards to become members. NALBOH is considering expanding its activities to create an active and ongoing national forum for state boards of health.

Meanwhile, efforts are ongoing to develop national and Washington State performance standards for public health. The processes may eventually produce a set of standards that could be used to measure and improve the effectiveness of state boards. (See the discussion of performance standards in Appendix F.)

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[5] Little Hoover Commission. *To Protect & Prevent: Rebuilding California's Public Health System*, April 2000, http://www.lhc.ca.gov/lhcdir/report170.html

[6] Michigan Public Health Association. *The Health of the Public in Michigan: A Vision for the Twenty-First Century*, September 2002, http://www.mipha.org/futurepubhlth.pdf

CONCLUSIONS AND NEXT STEPS

The primary reason for conducting this study was to understand the role of the Washington State Board of Health in a national context. The report demonstrates that the public health system in Washington State remains in the mainstream nationally; it is one of 30 states with a state board of health. If you look at the powers and duties of boards of health as a continuum—with boards that have direct oversight of the statewide public health system on one end and boards that a strictly advisory to the executive officer of the state health agency on the other—WSBOH appears to fall somewhere in the middle of the continuum.

While a few states eliminated their state boards of health during the 1990s, there is no nationwide trend that would point to the widespread elimination of state boards. Indeed, some states that eliminated their boards either have re-established them or are considering recommendations to re-establishing them.

This report shows that across the nation three-fifths of all states utilize a state board of health to maintain and strengthen public health protection and promotion. These boards generally share many similarities. They encourage public input into efforts to set public health policy. Many advise the governor on changes needed to the public health system in their respective states on a regular basis. And nearly all of them have members that are appointed by their governors for set terms to provide differing perspectives and views.

At the national level, the importance of an advisory and/or regulatory board in every state is being considered as a part of the model structure of state public health systems. While there is no consensus on the type of board that is most effective, it is clear that they are recognized as important advisors in every state. The resurgence of boards of health in some states demonstrates this.

This report also shows that national and state efforts are underway to develop standards to monitor and improve public health system performance. These efforts need to include governance and leadership standards. The information in this report could help in the development of these types of standards.

The authors recommend the following next steps for WSBOH and its staff:

1. **Provide survey information to key contacts at boards of health and health agencies in other states.**
2. **Share information with CDC and ASTHO to assist them in updating their records of state boards of health.**
3. **As other projects permit, be available to work with NALBOH and other associations as appropriate to support efforts to create a national forum for state boards of health.**
4. **As other projects permit, be available to work with the CDC National Public Health Performance Standards Program, the Washington Public Health Improvement Partnership, and other entities as appropriate to support efforts to develop governance tools applicable to state boards of health.**

APPENDIX A: WASHINGTON STATE BOARD OF HEALTH

The Washington State Board of Health is an advisory and regulatory entity. WSBOH is responsible for rule making on a wide variety of issues. These rules define a system that alerts us to new disease threats, protects the health of food and drinking water, prevents and controls the spread of communicable diseases, ensures that children receive appropriate and timely heath screenings and immunizations, keeps septic systems from contaminating streams and groundwater, and enhances the safety of a wide range of facilities. The Board advises the governor as well as all health related agencies in the state regarding public policy to protect and promote the public's health.

The Washington State Board of Health holds monthly meetings, sponsors public forums, and conducts citizen surveys in a variety of locations throughout the State. It works with interested parties to develop, assess, and revise rules and regulations based on health-related legislation and Board policy

The Board must submit to the Governor a both a biennial State Health Report, which reports on the people's health status and recommends priority health goals for state government and an annual report summarizing Board activities.

The Board has ten members. Nine members are appointed by the Governor and serve for specified terms. Two members must represent consumers, two must represent local elected officials, one must represent local health officers, and four represent health and sanitation experts. The tenth member is the Secretary of Health. WSBOH has an independent staff, however some of the staff are assigned by the State Department of Health. The Board is primarily funded by state dollars that flow through the State Department of Health, but are not from the department.

APPENDIX B: DESCRIPTIONS OF STATE BOARDS OF HEALTH

Alabama

State Board of Health and Committee of Public Health

Authority:
The Alabama State Board of Health has the authority to set policy, to regulate, and to enforce laws necessary for public health prevention and protection. It investigates the causes, promulgation, and means of prevention of diseases. The Board can inspect and take corrective actions to insure sanitary conditions in institutions and public or private establishments. Also it has the authority to adopt and promulgate rules and regulations providing proper methods for implementing health and quarantine laws of the state. Lastly, the Board serves in an advisory capacity to the state in regards to all medical matters, sanitation and public health issues.

Board Composition:
The State Medical Association makes up the State Board of Health. The Board meets annually. During other parts of the year, the State Committee of Public Health has the authority to act as the State Board of Health. The State Committee meets monthly. It is comprised of 12 members of the Medical Association's Board of Censors, and the four council chairs of the State Medical Association. The chairs are from the (1) Council on Dental Health, (2) the Council on Animal and Environmental Health, (3) the Council on the Prevention of Diseases and Medical Care, and (4) the Council on Health Costs, Administration, and Organization. The State Health Officer is an ex officio secretary to the State Committee of Public Health. The terms of service for the Committee members are staggered.

Regulatory Authority:
The State Board of Health sets policy regarding immunizations, vital statistics, control of infectious and noninfectious diseases, school health, food safety, water quality, emergency medical services, and regulation of health professions.

Local Health Jurisdictions/Departments:
Local health departments are under the authority of the state, local government, and state board.

Budget:
The Board and Committee are funded by annual dues special assessments, voluntary contributions, public or private grants, and other means not prohibited by the constitution and bylaws of the Medical Association and the State of Alabama. Members receive per diem at a rate of $100 per day when attending an official meeting or function of the Committee.

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Arkansas

State Board of Health

Authority:
The Arkansas Board of Health is a policy-making body. It sets numerous standards and regulations.

Board Composition:
The Board has 23 members appointed by the Governor. Board members include seven licensed medical doctors; one licensed dentist; one registered professional engineer; one licensed, professional nurse; one licensed pharmacist; one licensed veterinarian; one registered sanitarian; one hospital administrator; one consumer representative; one licensed doctor of podiatric medicine; one member of the Arkansas Public Health Association; and one member over 60 who is not practicing or retired from any occupation, profession, or industry regulated by the State Board of Health. The Board has quarterly board meetings.

Regulatory Authority:
The Board sets certification standards for the following: alcohol testing, drinking water, emergency medical services, individual sewage disposal systems, mammography accreditation, Medicare certification, plumbing professionals, recreation, water systems operators, public water systems, and HVAC/R mechanical inspectors. The Board sets the licensing regulations for alcohol and drug treatment facilities, backflow prevention repairmen and testers, health facilities licensure, HVAC/R professionals, lay midwifery, plumbing, radioactive materials, and septic tan cleaning. It sets permit regulations for cemetery processing, domiciliary care establishments, food service, food processing, general sanitation, hotels and motels, mass gatherings, medical waste, milk and dairy, mobile home parks, restaurants, septic tanks, sewage disposal, swimming beaches, recreational facilities, tattoo parlors, and x-ray/radiation producing equipment.

Local Health Jurisdictions/Departments:
Arkansas' public health jurisdictions are extensions of the State Department of Health. They are divided into ten management areas with 97 local health departments.

Budget:
The Board of Health is funded by the State Department of Health.

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Littlerock, AR 72205(501) 661-2400

Colorado

State Board of Health

Authority:
The Colorado State Board of Health has the authority to adopt or revise standards, regulation, and rules to administer the public health laws of the state. The Board may establish special advisory committees when necessary to advise and consult with the board concerning the public health aspects of any business, profession, or industry within the state of Colorado.

Board Composition:
The Governor appoints the nine members of the Board with the consent of the Senate. The members of the board include one representative of each of the seven congressional districts and two members from the state at large. Within those members, one must be a county commissioner. Each member serves a four-year term. Terms of service are staggered.

Regulatory Authority:
The Board has authority to adopt and revise rules regarding many public health matters. Areas of authority include: licensing standards for health care facilities; epidemic and communicable disease control; immunizations; reporting, prevention and control of HIV/AIDS related illness and HIV infection; detection, monitoring and investigation of environmental and chronic diseases; emergency medical services and the statewide trauma system; regulations to assure that hospitals, local health departments, emergency and bioterrorism preparedness; sanitary standards for facilities such as retail food establishments, child care centers, schools, recreational sites and penal institutions; Tobacco Education, Prevention and Cessation Grant Program; Nurse Home Visitor Program; newborn screening program; testing for alcohol and other drugs; primary drinking water regulations; regulations pertaining to swimming pools and natural swimming areas; radiation control; solid waste disposal sites and facilities; individual sewage disposal systems (ISDS).

Local Health Jurisdictions/Departments:
Local governments and local boards of health operate local health departments.

Budget:
Funded by the State Health Agency.

*Contact Information*Board of Health Staff:
Karen Osthus, Board Administrator
Phone: (303) 691-7702 Fax: (303) 691-7702
Email: karen.osthus@state.co.us

Linda Shearman, Program Assistant
Phone: (303) 691-7702 Fax: (303) 691-7702
Email: linda.shearman@state.co.us

Colorado Board of Health
C/O Colorado Department of Public Health and Environment
EDO-A5, 4300 Cherry Creek Drive S.
Denver, CO 80246-1530

Georgia

Board of Human Resources

Authority:

The Georgia Board of Human Resources oversees the Commissioner of the Department of Human Resources (DHR). The Board sets DHR policy and approves DHR's goals and objectives to "safeguard and promote the health of the people." DHR is responsible for programs that control the spread of disease; enable older people to live at home longer; prevent children from developing lifelong disabilities; train single parents to find and hold jobs; and help people with mental or physical disabilities live and work in their communities. The Division of Public Health resides within the Department.

Georgia also has the Board of Community Health that oversees the Department of Community Health. The Department of Community Health is responsible for health planning, health care purchasing, administrative efficiency, and health care access.

Board Composition:
The Board has 15 members who are appointed by the Governor. Members serve four-year terms. Seven members of the Board must be engaged professionally in rendering health services and at least five of these seven members must be licensed to practice medicine. The Governor is directed to take into account all the areas and functions encompassed by the department to the extent practicable.

Regulatory Authority:

The Division of Public Health resides within DHR. In that regard, the Board has authority over numerous public health programs including acute and chronic disease prevention and control, emergency preparedness, emergency medical services, children and family health (including children's medical services), environmental health, epidemiology, genetics, immunizations, HIV/AIDS, oral health, school health, WIC, and vital records.

Local Health Jurisdictions/Departments:
There are 19 health districts and 159 health departments.

Budget:
The Board is funded with state funds.

Contact Information:
Georgia Department of Human Resources
Commissioner Jim Martin
2 Peachtree Street, NW
Suite 29-213
Atlanta, Georgia 30303
www.dhr.georgia.gov/
404-656-4937

[INSERT HAWAII]

Idaho

Board of Health and Welfare

Authority:
The Idaho Board of Health and Welfare has rule making and advisory authority. The Board of Health and Welfare has the power to adopt, amend, or repeal rules and standards of the Department of Health and Welfare. Anyone who has been wronged by the actions or inaction of the Department of Health and Welfare has the right to a hearing by the Board or a Board-designated hearing officer. The Board gives final approval of any division administrators and regional director appointments.

Board Composition:
The Board has seven members who are appointed by the Governor with the advice and consent of the Senate. They serve for a four-year term. No more than four members can be from the same political party. Each member represents one of the seven administrative regions of Idaho. The Governor has the power to remove members in cases of conflict of interest or for other reasonable cause. Members are chosen for their interest and knowledge in environmental protection and health. A term is four years. Each year the Board elects a new chairman, vice chairman, and secretary.

Regulatory Authority:
The Board has the power to adopt, amend, or repeal rules and standards of the Department of Health and Welfare. It sets general rules for the promotion of the life, health, and mental health of the people of the state of Idaho. Regulatory areas include licenser and certification; laboratories and the standards of tests for environmental pollution, chemical analyses, and communicable diseases; mental health programs; minimum standards of health, safety, and sanitation of all public swimming pools; schools, hospitals, and other institutions; alcoholism; and emergency medical services.

Local Health Jurisdictions/Departments:
Local governments operate health departments with local boards of health.They have decentralized organizational control. The district health departments are autonomous and governed by local boards of health. The state has a contract with the health districts, so local governments directly operate health departments via the local board of health.

Budget:
The Board's budget is comprised of 68 percent federal funds and 32 percent state funds. The members of the Board are paid their travel and other expenses plus $50.00 per day during session and while traveling to and from meetings.

Contact Information:
Martha Puett, Executive Assistant
Idaho Board of Health and Welfare
450 West State Street, 10th Floor
Post Office Box 83720
Boise, ID 83720-0036
Phone: (208) 334-5546/334-5500

Illinois

State Board of Health

Authority:
The Illinois State Board of Health advises the Director of the Illinois Department of Public Health regarding needs assessments, statewide health objectives, policy development, and assurance of access to necessary services. It makes recommendations regarding state health priorities to the Governor through the Director in an annual report.

Board Composition:
The Board is composed of 15 members who are appointed by the Governor. The board members include a senior citizen 60 years of age or older; five physicians licensed to practice medicine in all branches (one representing a medical school faculty, one who is board certified in preventive medicine, and two in private practice); one dentist; an environmental health practitioner; local public health administrator; local board of health member; a registered nurse; a veterinarian; a public health academician; a health care industry representative; and two citizens at large. All members must be Illinois residents.

Advisory Authority:
Although the Board does not have regulatory authority it reviews the final draft of all proposed administrative rules, except emergency or preemptory rules. Areas of advisory authority include immunizations, vital statistics, EMS/Trauma, control of infectious and non-infectious diseases, school health, water, sewage disposal and regulation of health professionals. The Board also serves as an advisory group to the director for public health emergencies and control of health hazards. The Board advises the Illinois Department of Public Health its director about health policy, ways to resolve public health issues, and recommends studies to describe public health problems. It makes recommendations regarding state health priorities to the governor through the Director in an annual report. The Board submits its annual report on or before February 1 of each year on the health of Illinois residents to the Governor, General Assembly, and the public.

Local Health Jurisdictions/Departments:
There are 81 local health departments serving 85 counties. The health departments consist of five city, three districts, six multicounty units, one city-county,and 66 county health departments. Mixed centralized and decentralized control of LHJs with the state health agency.

Budget:
From the Illinois Department of Public Health (state health agency).

Contact Information:
James L. McGee, M.D., Chairman
Illinois Department of Public Health
535 W. Jefferson Street, 5th Floor
Springfield, IL 62761-0001
Phone: (217) 782-6187

Indiana

Executive Board of the State Board of Health

Authority:
The State Board of Health in Indiana is the state health agency. The entity that acts like a board of health is the Executive Board of the State Board of Health. The Executive Board is responsible for policy making for the State Board of Health, and approves the appointments made by the Health Commissioner.

Board Composition:
The State Health Commissioner serves as the Chief Executive Officer of the State Board of Health and as the secretary for the Executive Board of the State Board of Health. The Commissioner is appointed by the Governor, and serves at the pleasure of the Governor. The Executive Board consists of 11 members appointed by the Governor. The members of the Board select a chairman amongst themselves.

Regulatory Authority:
The Executive Board sets the regulations for licensing and regulation of health care providers, food protection services, indoor and radiologic health, sanitary engineering, and weights/measures. Areas of policy making include breast and cervical cancer program, children's special health care program, community health centers, diabetes, environmental health, Governor's Council For Physical Fitness and Sports, HIV/STD, immunization, lead poison and prevention, maternal and child health, nutrition, oral health, school screening forums, state labs, tobacco, tuberculosis, vital statistics, WIC, and women's health.

Local Health Jurisdictions/Departments:
Local governments directly operate local health departments with or without a local board of health. The Local Liaison's Office of the Indiana State Board of Health serves a formal liaison function. There are 94 local boards of health, 94 local health departments, and 94 local health officers. The Executive Board of Health is responsible for approving the appointment of the local health officers, and overseeing the programs and activities of the local health departments.

Budget:
The Board is funded by s.State and federal funds.

Contact Information:
Gregory A. Wilson, MD, Commissioner and Secretary of Executive State Board of Health
2 North Meridian Street
Indianapolis, IN 46204
(317) 233-1325

Iowa

State Board of Health

Authority:
The Iowa State Board of Health is the policy-making body for the Iowa Department of Public Health. The Board has the powers and duties to adopt, promulgate, amend, and repeal rules and regulations. It also advises or makes recommendations to the governor, general assembly, and the director of public health relative to public health, hygiene, and sanitation.

Board Composition:
The Board contains nine members, five of whom should be educated in the health professions, and four members who represent the general public. Board members are appointed by the Governor for three-year terms.

Regulatory Authority:
The Board of Health has the power to adopt, promulgate, amend and repeal rules and regulations. The Board also makes recommendations to the Governor, General Assembly, and the Director of Public Health regarding public health, hygiene, and sanitation. Federal and state legislative relations, Certificate of Need, Healthy People 2010 process, and the organized delivery systems. Other areas include medical examiners, health statistics, professional licensure, vital records, child death reviews, certificate of need, disease epidemiology and disaster preparedness, radiological health, environmental health, WIC, oral health, genetic testing and counseling, nutrition, immunization, communicable diseases, minority health, health prevention and promotion, and tobacco use prevention and control.

Local Health Jurisdictions/Departments:
The 99 local health departments in Iowa are under the control of the Iowa Department of Health. The local health departments' only source of funds is the Iowa Department of Public Health.

Budget:
The Board is funded 100 percent by the Iowa Department of Public Health.

Contact Information:
Barb Nerving, Executive Secretary
Iowa Department of Health
Lucas State Office Building
321 East 12th Street
Des Moines, IA 50319
Phone: (515) 281-4344

Kentucky

The Council for Health Services

Authority:
The Council for Health Services is advisory to the Citizen's Commission for Human Resources, the Secretary for Human Resources, the Commissioner for Health Services and other officials who are concerned with the delivery of health services.

Board Composition:
The Council is a citizen advisory body that contains no more than 19 citizens who were appointed by the Governor.

Advisory Authority:
Areas of interest include bioterrorism; chronic disease programs; certification, licensure, and permits; communicable diseases; oral health; environmental health programs; food and nutrition programs; infants and children's' health care; women's' health; men's health; health care for older adults; immunizations; laboratory services; public education and prevention programs; and vital records.

Local Health Jurisdictions/Departments:
There are 52 local health departments. Of these, 17 of these departments are health districts (multi-county), and two are city-county health departments.

Budget:
The budget solely consists of state funds.

Contact Information:
"The Council for Health Services"
Marcia Morgan, Executive Secretary
275 East Main Street
Frankfurt, KY 40621
Phone: (502) 564-7042

Maryland

Board of Review

Authority:
The Maryland Board of Review is an independent advisory body with authority to make recommendations to the Secretary of the Maryland Department of Health and Mental Hygiene regarding matters of the operation and administration of the Department, as the Board considers necessary. Also, the Board hears and determines any appeal from a decision or contested case of the Secretary or any unit in the Department that is subject to judicial review, or an action of or inaction by any unit in the Department for which the Secretary provides for review by the Board according to the rules or regulations.

Board Composition:
The Board of Review is a seven-member board appointed by the Governor with the advice and consent of the Senate. At least four of the members must be from the general public, and the other three must have knowledge and experience in one of the fields under jurisdiction of the Department. Each term is three years. Terms are staggered.

Regulatory Authority:
Topics of policy analysis include developmental disability; immunizations; environmental health; vial statistics; health plans and providers; HIV/AIDS; hospitals and clinics; licensing health care personnel; mental health; nutrition; oral health; and substance abuse.

Local Health Jurisdictions/Departments:
Local health jurisdictions are under the shared control under the authority of the Maryland Department of Health and Mental Hygiene, as well as local government and local board of health.

Budget:
The source of funding is the state (100%).

Contact Information:
Carlean Rhames-Jowers, Liaison
O'Conor Building
201 West Preston Street, Room 521
Baltimore, Maryland 21201
Phone: (410) 767-6499 Fax: (410) 333-7687
Email: br@dhmh.state.md.us

Massachusetts

The Public Health Council

Authority
The Massachusetts Public Health Council is a policy-making body. It promulgates rules and regulations, holds public hearings, approves certain appointments, and Determination of Need applications.

Board Composition:

The Council has eight members who are appointed by the Governor for six-year terms. The chairman of the Public Health Council is the Commissioner of the Department of Public Health. The Commissioner's term is concurrent with the Governor's four-year term. Three of the appointed members must be providers of health services, two of whom must be physicians. Five of the appointed members shall be non-providers; and at least one of whom shall be from a list of three people submitted by the Secretary of Elder Affairs. The council meets at least once a month, and at other times as determined by its rules or when requested by the Commissioner of Health or any four board members.

Regulatory Authority:
The Council disseminates rules and regulations. Its areas of interest include laws relative to health; sanitation; licensure and operation of convalescent or nursing homes; rest homes; infirmaries maintained in a town; and charitable homes for the aged. Also, it directs the Department in the study, suppression, or prevention of disease in the commonwealth. The Council is also concerned with HIV/AIDS; substance abuse; adolescent health; infant mortality; environmental health hazards; reduce health risks for the poor; health care for the elderly; and quality of health care. It make annual recommendations regarding to health legislation.

Local Health Jurisdictions/Departments:
Each city or town has a local board of health. Local health services care provided by local government, boards of health, health departments in other areas, or by the Massachusetts Department of Public Health.

Budget:
Funded 100 percent by the state health agency. Council members receive $25 per day while in conference, and necessary traveling expenses while performing their official duties.

Contact Information:
Linda Hopkins, Secretary
Public Health Council
250 Washington Street, 7th Floor
Boston, Massachusetts 02108
Phone: (617) 624-5069

Mississippi

State Board of Health

Authority:

The Mississippi State Board of Health is a policy-making body. The Board of Health organizes the State Department of Health into divisions and bureaus that are necessary to assign appropriate functions as required by law. The Board provides general supervision of the health interest of the people of the state. It establishes programs to promote the public health, which are to be administered by the State Department of Health. It makes and publishes all reasonable rules and regulations necessary to enable it to discharge its duties and powers and to carry out the purposes and objectives of its creation.

Board Composition:
The Board of Health consists of 13 members who are appointed by the Governor and confirmed by the Senate. The members must be actively professionally rendering health services or be consumers of health services and have no financial conflict of interest. Members should also be knowledgeable in at least one of the areas of jurisdiction of the Board. Terms are six-years and staggered in dates of expiration.

Regulatory Authority:

The Board regulates programs such as CHIP; First Steps; genetic services; health facilities; health statistics; immunizations; STDs, injury prevention; Maternal and Child Health; Tobacco Cessation and Control, trauma system, and water supply.

Local Health Jurisdictions/Departments:
The state is divided into nine public health districts with a total of 81 local health departments all run by the State Department of Health.

Budget:
The Board's budget is comprised of 100 percent state funds.

Contact Information:
H. Allen Gersh, M.D., Chair (601) 264-6000
R.A. Foxworth, D.C., Vice-Chairman (601) 372-0280
415 S. 28th Avenue
Hattiesburg, MI 39401
F.E. Thompson, Jr. M.D., M.P.H., State Health Officer (601) 576-7634
Mississippi State Department of Health General number (601) 576-7400

Missouri

State Board of Health

Authority:
The Missouri State Board of Health is an advisory body. The Board advising the director of the Department of Health regarding the priorities, polices, and programs of the department. The Board reviews all rules promulgated by the Department of Health and reviews the budget of the Department of Health. It provides advice on the administration of the State Hospital Subsidy Program, and the administering the Medical and Osteopathic Student Loan Program, the Family Practice Residency Program, and the Student Nurse Loan Repayment Program.

Board Composition:
The Board has seven members appointed by the Governor with the advice and consent of the Senate. Three members must be physicians and surgeons licensed by the state, one member must include a licensed dentist, and the other three members shall be representatives of persons, professions, and businesses that are regulated and or supervised by the Missouri Department of Health and the State Board of Health.

Advisory Authority:
The Board provides advice on the following areas: children with special health care needs; institutional licensing; institutional certifying for Federal reimbursement; state institutions and hospitals; state public health laboratory; environmental health; communicable disease prevention, maternal, child, and family health; nutrition; chronic disease prevention and health promotion; senior services; health standards and licensure; and certificate of need.

Local Health Jurisdictions/Departments:
There are 110 local health departments. Six districts and eight branch offices provide administrative and supervisory guidance to local health departments. Missouri has no local boards of health.

Budget:
The Board has 100 percent state funds.

Contact Information:
Ollie C. Fisher, D.M.D., Chair SBOH
10166 W. Florissant Avenue
St. Louis, Missouri 63136
Phone: (314) 869-9777 Fax: (314) 869-6934
Email: toothdk77@ad.com

Nebraska

State Board of Health

Authority:
The Nebraska State Board of Health is advisory to Nebraska Health and Human Services System (state health agency) and sets policy for the Department of Regulation and Licensure Credentialing Division.

Board Composition:
The State Board of Health is a 17-member board appointed by the Governor, with the consent of a majority of the members of the Legislature. The Governor is an ex-officio member of the board. The members of the Board include: two persons licensed to practice medicine and surgery one dentist, one optometrist, one veterinarian, one pharmacist, two nurses, one osteopath or osteopathic surgeon, one podiatrist, a chiropractor, a physical therapist, a professional engineer, hospital administrator, a credentialed mental health professional, and two laypersons interested in the health of the people of Nebraska. A term is five years with a two-term limit.

Regulatory Authority:
The Board has power to adopt and promulgate rules and regulations for the professions and occupations licensed, certified, registered, or issued permits by the Department of Health and Human Services System Regulation and Licensure. These include rules and regulations necessary to implement laws enforced by the department. The Board also determines polices of the department concerning health professions licensure. The Board has the duty to appoint members to 23 health care professional licensing boards and may help mediate issues related to the regulation of health care professionals, except for issues related to discipline.

Local Health Jurisdictions/Departments:
Nebraska has 27 local health departments or districts operated by local government. They each have a local board of health. The local health departments consist of 10 county health departments, one city/county health departments, and 16 multi-county health departments.

Budget:
The Board gets funding from the state health agency through general funds.

Contact Information:

Nebraska Health and Human Services System main number (402) 471-3121
System Advocate (person's role is to answer questions about HHS system)
Jodie Gibson, System Advocate (402) 471-8590. Email: jodie.gibson@hhs.ne.us

Ms. Monica Gissler, Program Manager
Nebraska State Board of Health
Nebraska Health And Human Services, Regulation and Licensure
Post Office Box 95007
Lincoln NE 68509-5007
Phone (402) 471-2948/6515
Fax (402) 471 0383

Nevada

State Board of Health

Authority:
The Nevada State Board of Health is "supreme in all non-administrative health matters". It has general supervision over all matters related to the preservation of the health and lives of citizens of the state and over the work of the State Health Officer and all district, county, and city health departments, boards of health, and local health officers.

Board Composition:
The Nevada State Board of Health consists of seven members appointed by the governor for a term of four years. Two members must be doctors of medicine who have been licensed to practice in Nevada and have been practicing medicine in Nevada for at least five years preceding their appointment. One member must be a doctor of dental surgery and licensed to practice and has been practicing in Nevada for at least five years prior to their appointment. One member must be a veterinarian who has been licensed and practicing in Nevada for at least five years prior to their appointment. One member must be a registered nurse who has been licensed and practicing in the state of Nevada for at least five years immediately prior to their appointment. One member must be a general engineering contractor or general building contractor licensed by the state, and one member who is a representative of the general public.

Regulatory Authority:
The Board sets reasonable fees for: licensing, registering, certifying, inspecting, or granting permits for any facility, establishment, or service regulated by the health division; programs and services of the health division; review of plans; and certification and licensing of personnel as well as the supervisory power over local health officers. The Board is responsible to define and control communicable diseases; regulate sanitation and sanitary practices; and to provide for the sanitary protection of food and water supplies. It also defines the powers and duties of local boards of health and health officers. The Board has many other specific responsibilities.

Local Health Jurisdictions/Departments:
Each county establishes a county board of health comprised of county commissioners, the sheriff, and the county health officer. County commissioners of two or more adjacent counties can establish a health district. Local cities can also have boards of health. The Nevada State Board of Health has supervisory power over local health officers, and has the authority to investigate cases of irregularity or violation of the law, and local health officers must aid in the investigation upon request. The Nevada State Board of Health has the power to govern and define the powers and duties of local boards of health and health officers, except with respect to NRS 444.440 to 444.620, inclusive, NRS 44.650, NRS 445A.170 to 445A.995, inclusive, and chapter 445B of NRS.

Budget:
The Board is funded 100 percent from the state health agency.

Contact Information:
Nevada State Board of Health
Dr. Joey Villaflor, Chair
505 E. King Street, Room 201

Carson City, Nevada 89701-4797
Phone: (775) 684-4200 Fax: (775) 684-4211

New Jersey

Public Health Council

Authority:
The New Jersey Public Health Council has the authority to set policy, to determine regulations, advise the New Jersey Department of Health, to study and investigate the public health activities of the state and to report its findings to the Governor and the Legislature.

Board Composition:
The Council has eight members who are appointed by the Governor with the advice and consent of the Senate. Members' terms are for seven years and their terms are staggered. The Council members are appointed for their knowledge and interest in public health. Two members must be licensed physicians, and one member a licensed dentist. The Council Chairperson is elected by the members for one year, or until another chairperson is elected.

Regulatory Authority:
The Public Health Council has the ability to amend, establish and repeal any part of the State Sanitary Code, which can cover any rules affecting public health, preservation or improvement of public health, and the prevention of disease in New Jersey. In addition the Council makes regulations regarding immunization against disease of all school children; prohibiting nuisances hazardous to human health; regulating the use of privies and cesspools; regulating the disposition of excremental matter; regulating the detection, reporting, prevention, and control of fly and mosquito breeding places; regulating the detection, reporting, prevention, and control of communicable and preventable diseases; regulating public funerals; regulating boarding homes for children; regulating the conduct of maternity homes and the care of maternity and infant patients therein; regulating the conduct of camps; regulating the preparation, handling, transportation, burial or other disposal, disinterment and reburial of dead human bodies; prescribing standards of cleanliness for public eating rooms and restaurants; regulating tattoo parlors; and regulating body piercing. The Public Health Council may modify or annual any order, regulation, by-law or ordinance of any local board of health.

Local Health Jurisdictions/Departments:
New Jersey has decentralized local health jurisdictions that are directly operated by local government with or without local boards of health. There are 500 local boards of health, 115 local health agencies and approximately 2,500 local government public health employees. .

Budget:
The Public Health Council is funded from state health agency.

Contact Information:
Ajhezza Gonzalez, Executive Director (Alise Davis, Executive Assistant)
New Jersey Department of Health and Senior Services
Office of Boards and Council – Room 801
Market and Warren Streets, Post Office Box 360
Trenton, New Jersey 08625
Email: Ajhezza.Gonzalez@doh.state.nj.us
Phone: (609) 292-9382 Fax: (609) 984-5474

Email: alise.davis@doh.state.ny.us

New York

State Public Health Council

Authority:
The State Public Health Council is a policy-making body that is also advisory to the New York Department of Health. The Council appoints one or more advisory committees with expertise in areas of public health concern such as health education, health manpower, economics, delivery of health service, sanitation problems, and interprofessional relationships.

Board Composition:
The Council has 15 members including the Commissioner of the Department of Health and 14 members appointed by the Governor with the advice and consent of the Senate, and the Commissioner of the Department of Health. Members must reflective the diversity of the states' population including the geographic regions and population densities throughout the state. Members serve six-year terms and remain in office until their successor is appointed and qualified. Vacancies must be filled within one year. The governor designates one member as chair. The Council must meet at least twice a year. Upon request of the Council, the Commissioner shall designate an officer or employee of the Department to act as secretary of the Council, and shall assign from time to time such other employees as the Public Health Council requires.

Regulatory Authority:
The Council sets qualifications for state, county, and city health officials; establishes regulations for promotion of health on Indian reservations; and regulations for the maintenance of hospitals for communicable disease. It sets policy regarding the efficiency of laboratories; communicable disease reporting and control; temporary farm worker housing; radiation and radioactive waste; handling and licensing of nuclear materials; epidemiological research; hotels and motels; backflow prevention; procedures for public notification of public health hazards. The Council reports to the Governor and the Legislature about the efficacy of wellness incentives—smoking status, physical fitness activities, frequency of physician evaluations, and dietary habits—that could allow insurance companies to reduce premiums for certain individuals aside from established community rates in the individual and group health insurance markets.

Local Health Jurisdictions/Departments:
The Commissioner of Health appoints local health officers who can be removed be local boards of health with consent of the Commission of Health. In some jurisdictions local health services are provided by the Department of Health. In others, the local governmental units, boards of health, or health departments provide the services. There are 59 local health units (58 county and 1 city).

Budget:
The council receives state funds. Members, except for the commissioner of health receive, $225 each day devoted to council work.

Contact Information:
Maria DiBari-Razzano, Secretary
New York State Public Health Council
Corning Tower, 14th Floor
Empire State Plaza

Albany, NY 12237
Phone: (518) 474-8009

North Carolina

Commission for Health Services

Authority:
The North Carolina Commission for Health Services has advisory and policy making authority. It has the power to adopt any rules necessary to protect and promote the public's health and is authorized to adopt rules necessary to implement the public health programs administered by the Department of Environment, Health and Natural Resources and the Department of Health and Human Services.

Board Composition:
The Commission has 13 members; four elected by the North Carolina Medical Society and 9 appointed by the Governor. The Governor appoints a licensed pharmacist, a registered engineer experienced in sanitary engineering or a soil scientist, a licensed veterinarian, The chair is chosen by the governor. The vice-chair is elected by the members of the commission and serves for two years or until the completion of his/her term of service on the commission. The Commission meets 4 times pear year with one meeting held conjointly with a general session of the annual meeting of the North Carolina Medical Society. The State Health Director shall submit an annual report on public health at this meeting. Special meetings can be called as needed.

Regulatory Authority:
The Commission's authority spans communicable disease control (including immunization requirements and control measures for AIDS and HIV infection) ; adolescent pregnancy prevention projects, sickle cell program, children's special health service program; home health services funds; restaurant sanitation standards; food safety; sewage collection, treatment, and disposal; standards for public water supply systems; hazardous waste management; solid waste management; mandated services for local health departments; state cancer registry; setting up mosquito control districts; and adult immunizations standards for adult care homes.

Local Health Jurisdictions/Departments:
The Department has seven regional offices. They provide technical assistance to local health departments, other health care providers, and local governmental units. Regional public health staff monitor local health programs and, in some, circumstance provide direct services. North Carolina has 100 counties, which are served by 80 county local health departments, and 7 multicounty local health departments.

Budget:
The Commission is funded by state and federal funds.

Contact Information:
James Bernstein, Secretary of Health
North Carolina Health and Human Services
2001 Mail Service Center
Raleigh, NC 27699-2001
(919) 733-4534

North Dakota

State Health Council

Authority
The State Health Council has regulatory authority to establish standards, rules, and regulations that are necessary for the maintenance of public health, including sanitation and disease control. It also has the authority to develop, establish, and enforce standards regarding construction, maintenance, sanitation, nursing procedures, and preservation of medical records in reference to hospitals and related medical institutions that give medical and nursing care. The Council may hold hearings on all matters regarding licensees of medical hospitals with reference to denial, suspension, or revocation of licenses and make appropriate determinations. The council is responsible for monitoring overall health care costs and quality of health care in the state. The State Health Council publishes an annual report on health care in the state.

Board Composition
The Health Council consists of eleven members appointed by the governor. The appointees shall consist of four persons from the health care field, five persons representing consumer interests, one person from the energy industry, and one from the manufacturing and processing industry. The Council members' terms are for three years and officers must be elected annually. The Council must meet at least twice a year and at other times as the council or its chairman deem necessary.

Regulatory Authority
The Council's regulatory authority consists of newborn metabolic disease screening tests, long-term nursing scholarship and loan repayment program, licensure of hospitals and medical facilities, vaccinations, immunization policy, vital statistics, permits, and sanitation.

Local Health Jurisdictions/Departments
Local Health Jurisdictions operate under decentralized organizational control in which local boards of health directly operate local health departments. There are 28 local health departments. Of those 28 health departments, 7 are multi-county, 4 are city/county, and 17 are county.

Budget:
The North Dakota Department of Health funds the State Health Council.
Council members are compensated $62.50 per day for official council business as well as mileage and travel expenses.

Contact Information:
Londa Rodahl, Administrative Assistant to State Health Officer
North Dakota Department of Health
600 E Boulevard Avenue
Bismarch, North Dakota 58505-0200
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Ohio

Public Health Council

Authority:
The Public Health Council is the primary rule-making body for the Department of Health. and the Council advises the Director of Health.

Board Composition:
The Public Health Council has seven members. The Ohio Revised Code (ORC) requires that the Department of Health have a director of health and a public health council. The council shall consist of three physicians, one registered nurse, one registered pharmacist, one registered sanitarian, and one member of the general public at least 60 years old and whom is not associated with or financially interested in the practice of medicine, nursing, pharmacy, or environmental health. The governor appoints members for seven-year terms. Each year one member's term expires at the end of June. The Council meets about every six weeks.

Regulatory Authority:
The Council adopts, amends, and rescinds rules pertaining to public health. The Council determines the number and functions of the divisions and bureaus and the qualifications of the chiefs of the divisions and bureaus with the Department. The Council also advises the director of health on issues regarding public health. Specific areas of authority include communicable diseases, immunizations, crippled children program, MCH/WIC, dental, sexually transmitted diseases, occupational health, nutrition, and environmental health.

Local Health Jurisdictions/Departments:
In Ohio the state department of health shares organizational control of local health jurisdictions with local government. The state is divided into four regions with 153 local public health agencies. This includes 25 county, 63-city-county, and 65 city health departments.

Budget:
The Public Health Council is funded through the state health agency.

Contact Information:
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(614) 644-8184

Oklahoma

State Board of Health

Authority:
The Oklahoma State Board of Health has authority to adopt rules, regulations, and standards of the Public Health Code. The Board is responsible for establishing the organizational structure of the Department of Health to carry out the provisions of the Public Health Code.

Board Composition:
The Board of Health has nine members who are appointed by the Governor and confirmed by the Senate for nine-year terms. Board members represent geographic regions of the state and at least four members must be licensed physicians and members of the Oklahoma State Medical Association. One member must be a psychiatrist and represent the state at large. Officers include president, vice president, and secretary-treasurer.

Regulatory Authority:
The Board sets rules, regulations and standards to carry out the Public Health Code including communicable disease, immunization, reproductive health, child health, consumer protection, chronic disease, health promotion and prevention, tobacco use prevention, unintentional injury prevention, vital statistics, and developing a trauma system in Oklahoma.

Local Health Jurisdictions/Departments:
The State Department of Health has centralized authority over all local health departments, except for in two counties. There are 69 local health departments, 67 county health departments, and two city-county health departments. In some jurisdictions the state health agency provides the mandated local health services.

Budget:
The Board has state funds, grants, allotments, gifts, and appropriations.

Contact Information
(405) 271-4200
Dr. Ron Graves, Chair
1000 NE Tenth
Oklahoma City, OK 73117:

Oregon

Public Health Advisory Board

Authority:
The Oregon Public Health Advisory Board serves as an advisory body to the Director of Human Services on policy matters related to the operation of the Department of Human Services. The Public Health Advisory Board also provides a review of statewide public health issues and makes recommendations to the director. It participates in public health policy development.

Board Composition:
The Oregon Public Health Advisory Board consists of 15 members who are appointed by the Governor and serve four-year terms. Half of the members must represent members of the public representing the state as a whole and the other half must include representatives of local government and public and private health providers. The board must meet at least quarterly.

Advisory Authority:
The Board advises the DHS Director of Human Services on policy matters related to operation of DHS, provides review of statewide public health issues and makes recommendations to the Director, and participates in policy development. These areas include child and family health; immunization; reproductive health; chronic disease and health promotion; disease prevention and epidemiology; STDs; bioterrorism; HIV/AIDS; communicable diseases; emergency medical services; environmental health; food safety; lead poisoning; pesticide poisoning and prevention; vital statistics; injury prevention; laboratories; medical marijuana; and public health planning.

Local Health Jurisdictions/Departments:
The governing body of each county shall constitute a board of health ex officio for each county of the state and may appoint a public health advisory board to advise the governing body on matters of public health. Counties may contract out the local public health authority (LPHA) role or return it to the state. There are 36 counties and 34 local health departments, 31 operated by county government, three counties have contracts with another entity to be the LPHA, one county has returned the authority to the state, and one county has an arrangement with a neighboring county for coverage.

Budget:
Funding for the Public Health Advisory Board is completely from the state health agency. Board members receive $30 per day or portion of a day that they spend on official board business. They are also entitled to travel and other incurred expenses.

Contact Information:
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South Carolina

The Board of Health and Environmental Control

Authority:
The South Carolina Board of Health and Environmental Control supervises the operations of the Department of Health and Environmental Control (state health agency). The Board elects the commissioner of the South Carolina Department of Health and Environmental Control. The Board also approves the budget and department sponsored legislation; and acts as an adjudicatory body for appeals of Department regulatory decisions.

Board Composition:
The Board of Health and Environmental Control has seven members who are appointed by the Governor with the advice and consent of the Senate. One member is from each of the state's six congressional districts and one member from the state at large. The Board elects its own officers annually. Each member serves a four year term.

Regulatory Authority:
The Board's authority spans response to environmental emergencies, laboratories, hazardous chemicals, restaurants, family planning, children with special needs, tuberculosis, vital statistics, immunizations, solid and hazardous waste, nutrition, public water supplies, home health services, HIV/AIDS, STDs, environmental permits, shellfish, oral health, certificate of need, emergency medical services, rural health care, WIC, health needs of minority populations, injury prevention programs, food safety, lead poisoning, and radioactive materials storage and transport.

Local Health Jurisdictions/Departments:
Local health departments are operated by the state health agency or State Board of Health. There is a county health center in each of the state's 46 counties. Each county health department is part of a district. There are two to six counties in a district. Management of health services is provided through the district office. The district health director reports directly to the Deputy Commissioner for the state health agency.

Budget:
Funds are comprised of state and federal funds.

Contact Information:
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Columbia, South Carolina 29201
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Texas

State Board of Health

Authority:
The Texas board of Health supervises the Commissioner of Health's administration and enforcement of the health laws of this state.

Board Composition:
The Board of Health is composed of six members appointed by the Governor with the advice and consent of the Senate. Four members must have a vested interest in the services provided by the Department of Health, and two members shall represent the general public. Each member must complete a training program that complies with the statutes of the Texas administrative code 11.0055 to vote, deliberate, or be counted as a member in attendance at a meeting of the board. Members serve staggered six-year terms with two member's terms expiring on February 1st of the odd numbered years. The Governor designates one member as chairman and one member of the Board as vice chairman. The Board meets at least quarterly on dates determined by the Board and shall hold special meetings at the call of the chair.

Regulatory Authority:
The Board is responsible for prevention of disease; promotion of health; indigent health care; protection of parents' fundamental right to direct the health care and general upbringing of their children; acute care services for which the department is responsible; health care facility regulation for which the department is responsible; the licensing of health professions for which the department is responsible; and all other health-related services for which the department is responsible. The Board has 25 advisory committees whose members provide technical expertise and consumer input on a variety of issues including: Animal Friendly, Asbestos, Asthma and Allergy Research, Children with Special Health Care Needs, Code Enforcement Officers', Device Distributors and Manufacturers, Family Planning, Governor's Emergency Management Services and Trauma, Indigent Health Care, Kidney Health Care, Medical Radiological Technologist, Oral Health Services, Osteoporosis, Poison Control Coordinating, Preparedness Coordinating Council, Promoter or Community Health Worker Training and Certification, Registered Sanitarian, Respiratory Care Practitioners, School Health, State Preventive Health Advisory Committee Texas HIV Medication, Texas Oyster Council, and Texas Radiation.

Local Health Jurisdictions/Departments:
Local health services are provided by the state health agency, local governmental units, local health departments, or boards of health. Texas has 71 governmental local health departments including 33 county, 27 city-county, eight city, and three multicounty health departments.

Budget:
The Board is funded by state and federal funds.

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Utah

Health Advisory Council

The Utah Health Advisory Council previously existed until 1993 when the Health Policy Commission was created. The Health Policy Commission was in existence from 1994 until 2000 when it was abolished by the legislative sunset reviews. After the commission disbanded, the Utah Department of Health began discussions with Governor, local health departments and advocacy groups, etc., to reinstate the Council's advisory role. "We need the Council to be reconstituted to bring more community perspective to the table as we make difficult policy and budget decisions," said Rod Betit, Executive Director, UDOH1. The first Council meeting was held August 22, 2002.

Authority:
The Utah Health Advisory Council advises the Executive Director of state Department of Health.

Board Composition:
The Utah Health Advisory Council consists of 9 members who are appointed by the Governor. Council appointees are based on having an interest in or knowledge of public health, environmental health, health planning, health care financing or health care delivery systems. Geographic, ethnic, political party and gender balance was considered in the appointments. The Council members are all volunteers and they include professionals and nonprofessionals, with the majority being non-health professionals. No more than 5 members can come from the same political party. They serve four year terms with half expiring every two years. No member can serve more than two consecutive terms. The Governor select the chair. The council must meet at least quarterly.

Advisory Authority:
The Board provides advice on environmental testing and toxicology, food safety, environmental health, communicable diseases, laboratory improvement, managed health care, Medicaid/Medicare, children's insurance and access initiatives, health care financing, community and family health, children with special health needs, emergency medical services, rural health care, vital records/statistics, health facility licensure, and health professionals licensure.

Local Health Jurisdictions/Departments:
Local governments are responsible for creating local health departments with appointed boards of health. Local health departments are legally separate and autonomous from the Utah Department of Health. There are 12 local health departments, six of those are city/county (single county) and six are multicounty (health district).

Budget:
Funding is completely from the state health agency.

- *Contact Information*:

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Vermont

State Board of Health

Authority:
The Vermont State Board of Health is both a regulatory and advisory body. The Board has the authority to make and promulgate rules and regulations to all matters relating to the preservation of the public health. The Board can delegate responsibilities and authority to the Commissioner of the Vermont Department of Health. And it is advisory to the Commissioner and to municipal officers and local health officers.

Board Composition:
The board consists of seven members who are appointed for 6-year terms. The governor appoints members biennially with the advice and consent of the Senate. The governor designates the chair. Three members of the Board must be doctors, one licensed to practice medicine and surgery in the state, one with special training and ability in psychiatry, and one licensed to practice osteopathy, surgery and obstetrics. One member must be licensed to practice dentistry and three members must be not be medical or dental professions. The governor shall fill any vacancy occurring in the membership for the unexpired portion of the term.

Regulatory Authority:
The Board has regulatory authority for immunization policy, new born screening, vital statistics, emergency medical services, control of infectious and noninfectious diseases, chronic diseases, school health, food safety, restaurant regulation, and licensure of health professions. The board's jurisdiction over sewage disposal includes emergent conditions which create a risk to the public health as a result of sewage treatment and disposal, or its effects on water supply, but does not include rulemaking on design standards for on-site sewage disposal systems. The board also has advisory authority over water supply, drainage, construction, heating, ventilation and sanitary arrangements of public buildings.

Local Health Jurisdictions/Departments:
The local health units are part of the state health agency. There are 12 district offices that provide services to local areas and perform some of the same basic functions as local health departments in other states. The districts consist of several towns and units and have no relationship to county governments.

Budget:
Funding is completely from the state health agency. Board members receive $30 per day as well as travel and other incurred expenses.

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Virginia

State Board of Health

Authority:
The Virginia State Board of Health makes, adopts, promulgates and enforces regulations necessary to carry out its responsibilities or those of the Commissioner of Health or the Department of Health. The Board advises the Governor on all health-related issues. It identifies health- related issues, formulates policy, and educates citizens, local governments, other state agencies, the legislature, and other related health care entities about public health. The Board advocates concerning health care reform and advancing quality of life through improved health.

Board Composition:
The State Board of Health consists of 13 residents of Virginia appointed by the Governor. Two members of the Board are members of the Medical Society of Virginia, one member is a member of the Virginia Pharmaceutical Association, one member from the State Dental Association, one member is part of the Virginia Nurses' Association, one member is a member of the Virginia Veterinary Association, one member is a representative of local government, one member is a representative of the hospital industry, one member represents the nursing home industry and two members are consumers with expertise in health care analysis, policy, and financing.

Regulatory Authority:
The Board has regulatory authority and formulates programs for environmental health services, laboratory services, preventative/curative/restorative medical services, home health care services, medically indigent, HIV/AIDS, community health prevention and promotion, communicable, contagious and infectious diseases, health facilities licensing, and health care professions licensing. The programs would be provided by the Department of Health on a regional, district or local basis. The Board has the power to make emergency orders and regulations for the purpose of suppressing dangers to the public life and health such as communicable, contagious and infectious diseases..

Local Health Jurisdictions/Departments:
Local health departments are operated directly under the state's authority and are run by the state health agency or the state board of health. There are 119 local health departments in Virginia. The local health departments consist of 13 city/county departments, 24 city health departments, and 82 county health departments. Within these local health departments there are 56 satellite clinic offices for a total of 175 clinic sites.

Budget:
The Board is state and federally funded.

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West Virginia

Public Health Advisory Council

Authority:
The West Virginia Public Health Advisory Council is an advisory body to the commissioner of health. The Council advises the commissioner on the provision of adequate public health services for all areas in the state. The Council is currently set to sunset July 1, 2003.

Board Composition:
The Public Health Advisory Council is comprised of 15 members appointed by the governor with the consent of the Senate. The state insurance commissioner serves as a member ex officio. Twelve of the members shall represent local health officers, local health departments, county elected officials, sanitarians, the hospital association, the medical association, emergency medical services, primary care providers, nurses, higher education, and the state chamber of commerce. Members were initially appointed for one, two or three year terms. If the Council continues, members will each serve 3-year terms. The Council meets at least twice per year.

Advisory Authority:
The Public Health Advisory Council may review all rules and recommend revisions to them. It reviews all performance-based standards and assists the commissioner in the development and implementation of a coordinated, population-based prevention oriented program that promotes and protects the health of all citizens of West Virginia. The Council also advises the commissioner about the need for additional or special advisory committees.

Local Health Jurisdictions/Departments:
The state does not have local health jurisdictions. It is divided up into eight public health management districts.

Budget:
The Public Health Advisory Council is funded by the state.

Contact Information:

APPENDIX C: COMPARISON OF SBOH AREAS OF AUTHORITY

[INSERT CHART]

APPENDIX D: A POSSIBLE NEW CALIFORNIA STATE BOARD

The State of California established a state board of health in 1870, becoming the second state to do so. Since then California, like Washington, witnessed profound changes in health status as the result of disease detection, prevention, protection and control. The California State Board of Health existed until 1970 when it was abolished. Up until that time, the public health system included a physician director with considerable independence and a board of health with regulatory powers. Funds were provided to local health agencies, which in turn agreed to meet minimum standards of service.

California's governor and state legislature recently charged its Milton Marks "Little Hoover Commission" on California State Government, Organization, and Economy with recommending specific ways the state can fulfill its obligation to provide defense against illness and injury. The Commission found that the state public health leadership and organizational structure in California is ill-prepared to fulfill the primary obligation of reducing injury and death from threats that individuals cannot control, such as environmental hazards, bioterrorism and emerging infectious diseases.

The report issued by the commission in April 2003—*To Protect & Prevent: Rebuilding California's Public Health System*—states that a significant gap exists because there is no public forum to identify needs, expose problems, and set priorities. There is no public process for public at risk; no expert involvement in a public venue; no venue for linking public efforts; and no venue for systematically thinking through health-related issues. The report The report states that the crucial partnership between the state and local agencies "eroded and then dissolved" following the elimination of the state board.

The Commission recommends that the governor and legislature establish a public health department that is focused on emerging threats, with physician and science-based leadership and an advisory board of health linking California's health assets and experts. The state board of health would provide a mechanism for public and expert involvement in the development of policies, regulations, and programs administered by the department of health or directly affecting the health of Californians. It would be a part-time, volunteer and scientific public health board whose members would be appointed for fixed terms by the governor and legislature and be charged with a fiduciary responsibility to represent the public interest and protect the public's health. Members would include: a dean of a California school of public health; a dean of a California school of nursing, a dean from a California school of medicine, the president of the California Conference of Local Health Officers, the health officer of a large metropolis, a rural health officer, the physician leader of the state's medical emergency response system, two public members of nation stature, and surgeon-general-director of the Department of Public Health. The surgeon general would serve as chair of the board. The Board would have independent professional staff.

During its discussions, and in the appendices to the report, the commission pointed to Washington as a model state board of health that fulfills the responsibility for public input, expert involvement, coordination, and policy development.

APPENDIX E: POSSIBLE STATE PUBLIC HEALTH ACT

The laws that create each state public health system differ throughout the country. With the focus on improving the functions of the overall public health system nationally, the need for comparability of state systems has increased. The Turning Point Public Health Statute Modernization Collaborative has prepared a draft entitled *The Model State Public Health Act* that is currently under review nationally. In the proposed act, each state would have a state health agency along with a public health advisory council as part of the state public health infrastructure. The advisory council in the draft act fits the definition of a board according to the criteria identified above under the methodology section of this report. However, it is unclear why the model act recommends an advisory council/board rather than one with both advisory and regulatory responsibilities

The advisory council described in the model act would be advisory to the state public health agency and to the governor on all matters related to the public health system. The council would have 15 members, including representatives from the state public health agency, local public health agencies, tribal public health agencies, health care facilities, health care providers, health insurers and the general public. Every five years the board would create a comprehensive public health plan that assesses and sets priorities for the state public health system. The plan would be developed in consultation with representatives from public and private sector partners within the public health system. The comprehensive public health plan would be submitted to the governor and state legislature and would include recommendations for legislative amendments.

APPENDIX F: PUBLIC HEALTH PERFORMANCE STANDARDS

The public health system needs authority and resources to carry out its responsibilities in collaboration with other agencies, organizations, communities and individuals. With the "Essential Services" clearly defined at the national level (see Appendix C), national, state, and local organizations and agencies have recognized the need to assure the public health system is working effectively to protect, promote, and improve the public's health regardless of where people may live or work.

National Public Health Performance Standards

At the national level, public health performance standards have recently been developed by a partnership known as the National Public Health Performance Standards Program (NPHPSP) Partnership. NPHPSP; a collaborative effort between the CDC and five public health organizations including the Association of Public Health Agencies (APHA), the Association of State and Territorial Health Officials (ASTHO), the National Association of County and City Health Officials (NACCHO), NALBOH, and the Public Health Foundation (PHF). The purpose of the NPHPSP is to develop measurable performance standards that public health systems and local boards of heath or other governing bodies can use to ensure the delivery of the Essential Public Health Services.

The CDC conducts the overall coordination, with each partner playing a lead role in a specific piece of the program. ASTHO, NACCHO, and NALBOH led the development of performance standards for state and local public health systems and governing entities. APHA has been a leader in the area of marketing and communications. The Public Health Foundation has been active in several research areas, such as validity testing and researching technical assistance resources. In addition a new partner, the National Network of Public Health Institutes, will provide a link between the program and state public health institutes across the nation.

To date, the performance standards fall into three categories: (1) the State Public Health System Performance Assessment Instrument; (2) the Local Public Health System Performance Assessment Instrument, and (3) the Local Public Health Governance Performance Assessment Instrument. A state public health governance performance assessment instrument does not exist.

1. The State Public Health System Performance Assessment Instrument (State Instrument) focuses on the state public health system. It defines the "state public health system" as the state public health agency (or organizational unit of the State Health officer) working in partnership with other state government agencies, private enterprises and voluntary organizations that operate statewide to provide services essential to the health of the public. This instrument was not intended to and does not appear to be applicable to state boards of health.
2. The Local Public Health Performance Instrument (Local Instrument) focuses on the "local public health system" or all entities that contribute to the delivery of public health services within a community. This system includes all public, private, and voluntary entities as well as individual and informal associations.

3. The Local Public Health Governance Assessment Instrument (Governance Instrument) focuses on the governing body ultimately accountable for public heath at the local level. Such governing bodies may include boards of health or county commissioners.

At this time, the governance instrument has limited use for state boards of health. Only some of the indicators may be applicable. For example, the parts related to the governance assurance function focus on assuring legal authority, resources, policy making, and collaboration. NALBOH is working with a few states to determine how the governance instrument could be utilized to assess state board of health performance.

Washington State Performance Standards

The Washington State Public Health Improvement Partnership (PHIP) is a state effort to ensure that Washington's public health system is prepared to address every challenge that could jeopardize the health of Washington residents. The State Department of Health, the State Board of Health, the Association of Local Public Health Officials, and the University of Washington comprise the Public Health Improvement Partnership. In 2001 the PHIP published *Standards for Public Health in Washington* to provide a framework to measure performance of the state's public health agencies and programs. The report presents standards intended to explain what every citizen has a right to expert of the government public health system. According to the Washington's *2002 Public Health Improvement Plan*, since the standards were developed a baseline assessment of 72 local and state programs has been completed. The assessment findings are intended to help set priorities and target resources to improve performance. The findings showed that Washington's public heath system performs strongest in the topic areas of assessment, managing communicable disease and other risks, and in prevention and community health promotion. Weaker areas included protecting environmental health and assuring access to critical health services. Areas not thoroughly addressed included administrative standards including governance, finance, human resources and information technology.

The PHIP recognizes the need for governance and leadership performance standards and is currently developing them. These standards are directly applicable to the responsibilities of state and local boards of health. They are necessary to assure that the public health system addresses current needs. Governance and leadership standards will be useful for boards to evaluate their work and to clarify the roles they play in the public health system.

The efforts to develop performance standards at the national level and at the state level demonstrate the focus on public health system performance and the desire to guarantee system effectiveness. However, some tension exists between performance standards developed nationally for states and those developed by an individual state. Washington's effort has been underway for many years and has involved multiple partners from the public and private sectors. The national effort also demonstrates the importance of strong partnerships to effectively assess and improve the public health system. States can benefit from both approaches.

ACKNOWLEDGEMENTS

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Editor: Craig McLaughlin, MJ

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THE WASHINGTON STATE BOARD OF HEALTH

Members

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Staff

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